pt. Health,
., & Welfare
S. Public
lth Service

. S. 300
ev. 1-57

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

46376
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12359

1. PLACE OF DEATH
a. COUNTY St Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 ST. LOUIS CITY HOSp. #1. Length of stay in lb 5 DAYS 2 0/6

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY St Louis
c. CITY OR TOWN St Louis Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 5331 EASTON Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First WILLIS Middle SUMMERSET Last

4. DATE OF DEATH Month Day Year DEC. 23, 1957

5. SEX MALE
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-2-1880
9. AGE (In years last birthday) 77 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) Williamson Co., Ill.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME William Summerset
13b. MOTHER'S MAIDEN NAME Eveline McDonald
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Bonnie Deming Address 5531 Easton St Louis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Lymphocytic Leukemia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 204.0
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/18/57, to 12/23/57 and last saw her/him alive on 12/23/57
Death occurred at 2:45 A.M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Milton H. Seifert M.D.
22b. ADDRESS 1515 LAFAYETTEAVE.
22c. DATE SIGNED 12/23/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 12-24-57
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) MARION (State) Illinois

24. FUNERAL DIRECTOR Mitchell Fun. Home ADDRESS MARION ILL
25. DATE RECD. BY LOCAL REG. DEC 24 '57
26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. M.J.B.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Frank Prollopf

Licensed Embalmer No. 4356

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.